Physician Manpower

THE IMPENDING NEEDS for physician manpower are truly awesome. The reasons are all too simple and all too obvious. These growing needs are a reflection of an almost exponential growth in medical science and a national and world-wide social commitment to better health for all. Scientific progress may perforce be slowed but it will not stop; while the national and international needs are certain to grow as medical skills improve and as backward peoples and those who are at a disadvantage everywhere demand equal opportunity for health in an increasingly complex and interdependent world society.

Elsewhere in this issue is to be found a joint statement by representatives of the American Medical Association and the Association of American Medical Colleges calling for immediate substantial increases in the enrollment of existing medical schools and for the prompt creation of new ones to meet longer range needs. The statement also calls for innovation and change in educational programs and for adequate financial support from governmental and private sources.

It is quite obvious that if medicine is to play its proper role in a national and international society and if sick, injured or emotionally disturbed patients are still to be served by physicians and not by machines and technicians alone, then both greater numbers and many new kinds of physicians must be produced as rapidly and efficiently as possible without sacrifice of quality either in the caliber of the student or of his training.

The AMA and the AAMC are to be commended for sounding this call. It is being heeded in California.

The Confusion of Tongues

IN GENESIS IS RECOUNTED the story of the first confusion of tongues. Men had sought to create a direct conduit into Heaven in the form of a huge tower at Babel. The project was foiled when language became confounded and men no longer understood one another's speech. Perhaps there is a lesson in this biblical tale as we ourselves seek to build a conduit to the state of good health in the form of a health care delivery system or systems which will provide equal access to every person as a matter of his right.

There is today a considerable confusion of tongues with respect to what is meant by many of the words and phrases which are commonly used in connection with the provision of health services. To wit:

- The word *consumer* as used in discussions of health care may refer to the patient from the standpoint of a physician, the purchaser of health services in the mind of an economist, and the public itself or the voter in the view of government or a politician.
- *Group practice* may refer to three or more physicians in a single specialty and essentially in solo practice who share certain arrangements for reasons of convenience and economy, it may refer to multispecialty groups or clinics of various size and composition which provide care on a fee for service basis, or it may refer to a multispecialty group which contracts to provide specified groups of persons with all the health services they need for a capitation fee of so much for each person.
- *Closed* panel is a term often applied to the capitation form of group practice but is equally applicable to the larger multispecialty groups whose physician panels are closed and who practice for fee for service. In the more common usage, closed panel refers to situations where a closed group of patients and a closed group of physicians are in an exclusive contractual relationship for health care for a given period.
- The word *Prepayment* may properly be applied to insurance premiums for indemnity or service plans, but there are some who use this term only to mean prepayment by capitation for complete services. These persons usually do not recognize other forms or degrees of prepayment. The recent proposal of the California Medical Association and California Blue Shield to contract with the state to provide all physicians' services for persons under the Medi-Cal program is still another dimension of prepayment.
- *Comprehensive, continuing* and *mainstream,* as used to describe health care and health services, are terms in common use but without generally understood or accepted definition or meaning.

These are only a few examples of the confusion of tongues in health care. It is curious but true that the scientific and technologic aspects have far more precise terminology than do the social, economic

or political aspects of health care. Scientists and technologists have long recognized that they can communicate with one another and make progress only when the terms and symbols they use are clearly defined and the meaning clearly understood by all concerned. Symbolism and communication in the social, economic and political aspects of health care delivery systems or conduit have yet to become scientific in this very basic sense of precise definition of meaning.

The biblical tale told in the eleventh chapter of Genesis and the practical experience of modern science both seem to point to the same thing. We must first unconfound our language so that we can comprehend one another's speech. Only then can we understand one another and by working together make orderly progress toward the heavenly state of good health for all.

Abdominal Aortic Aneurysms

THE PAPER BY Moore and co-authors concerning misdiagnosis in patients with abdominal aortic aneurysms is particularly pertinent when reviewed in the context of the past 15 years of advance in vascular surgery. An untreated abdominal aneurysm is a lesion of a highly lethal potential. The mortality from elective aneurysmectomy by experienced vascular surgeons has shown a progressive decline from the original figures of 20 percent to the present norm of 2 to 4 percent. Yet during this same interval these surgeons have been unable to reduce the mortality for emergency aneurysmectomy for aortic rupture to below approximately 50 percent.

The need for diagnosis before rupture occurs is clear. Reliance upon the former textbook criteria where the diagnosis of aneurysm is suspected only if there exists a large pulsatile mass with pain radiating to the back will allow most aneurysms to go to rupture undiagnosed. In this reviewer's experience with a large series of cases of ruptured aneurysms dealt with on an active vascular surgery service, in over 75 percent of the patients the diagnosis of aneurysm was not made before rupture. Most were free of symptoms until rupture occurred. Ninety percent of these patients had been examined by a licensed physician within the previous year.

The reason for the failure in early diagnosis became clear on review of the preoperative clinical events in the group of patients admitted for elective aneurysmectomy before rupture had occurred. In all of them the diagnosis had been first made by the referring physician. Forty percent of these patients, however, denied any form of abdominal symptoms other than a subjective throbbing sensation in the abdomen in those with particularly large aneurysms. Thirty percent had additional vague abdominal symptoms which prompted diagnostic investigation and from x-ray studies directed toward other organ systems the aneurysm became evident. In most of these patients, however, the size of the aorta could be accurately determined by careful abdominal palpation. That many of the lesions were first found by the radiologist suggests that thorough vascular examination is still omitted by some physicians.

The large number of patients in Dr. Moore's series in whom the diagnosis was missed by both the referring physician and the admitting physician in his own institution indicates that palpation for the size of the aorta was not included in the physical examination. Aortic rupture rarely occurs in aneurysms of less than 8 cm in diameter, yet the admitting physician failed to diagnose aortic rupture in four patients, and even the ward physician erred in three of these patients. Dr. Moore's message is clear and should be read by all members of the medical profession at large.